Q&A
September 2014 MIHP Coordinator Meetings

Typos on New Forms

MRI
Pg 2. If no, are you planning to begins school in the near future?
Pg 5. Under dental. Within the past 2 year years.
More thatn 5 years
Pg 12. Deprssion Followup Screening (heading)
Pg 13. Deprssion at top of page.

IRI
Infant Safety POC 2. Fire arms – one word
Maternal considerations has 1/1/14 date I007 – is that right?
If more than 1 family member on MIHP – is narrative document sufficient?

The typos have been corrected. Please continue to report any others you may find.

POC 2

1. Does POC 2 date need to match POC 3 date? It was our understanding that POC 3 signature date must be within 10 days of POC 2 being pulled.
2. Date of POC 2 is date POCs are pulled (after MIHP results page). Date of POC 3 (on checklist page) is date of signature of other discipline.
3. POC 2 date on checklist – I have been doing same date as POC 3 because it was not valid until both disciplines signed – clarity.
4. If the checklist is to make sure we have all the forms in the charts: Do we need to have the date field for CP 1, 2 & 3? It is confusing and agencies got cited for unclear instructions instead of policy violation.

   Yes, on the Forms Checklist, the date of the POC 2 and the date of the POC 3 should be the same. This is the date when the second professional signature is obtained, indicating that the two professionals concur on the POC. This will be required in Cycle 5 (beginning November 1, 1014).

5. POC 2 clarification on DATE in 1st column. Date it when you:
   1. Change a risk level – i.e., mod to high; what if they go back to mod and them back to high, etc.?
   2. Add a POC that was not on the initial Risk Identifier.
   3. Then on D/S – if you feel patient became low or mod (previously high) do you go back to POC 2 and add the date?

   Yes on #1, and yes on #2. On discharge, you do not have to go back and re-date the POC 2 if no risk exists - you would then put "None" on Discharge Summary. But if there is an existing risk that has decreased, you would have to go back to the POC 2 and add the date.

6. POC 2 – Column one dated if you add a domain that's not on the Risk Identifier summary?

   Yes, you do need to insert the date in Column 1 when you add a domain based on professional judgment.

7. Op Guide 8.18 Column 1: We aren't supposed to add the initial date on POC 2s? Do we only put a date if POC 2 is changed or if we add a POC 2 at initial that wasn't on the risk score sheet?

   You are required to insert the date whenever you add a domain based on professional judgment or when you change the risk level based on the criteria in Column 2 on the POC 2.

8. How do you or when do you change the initial POC 2 intervention level? If it was high, when do you know when to change it to moderate or low? Please help clarify this to new MIHP case workers!

   You would change the risk level when the beneficiary's situation changes so as to match the criteria in Column 2 of the POC 2.

9. If someone scores moderate, do we have to put date on all low interventions? (Because it will say includes all low and moderate interventions.)

   You don't have to use all of the interventions. Only date the interventions that you actually provide. Remember that you can only provide interventions at or below the beneficiary's current level of risk; you cannot provide interventions above the beneficiary's current level of risk.

Professional Visit Progress Note

1. On the *Professional Visit Progress Note*, *is it acceptable to have different dates for the date the visit was completed on the front of the note and the date that is listed with the MIHP Professional's signature on the back*? The question came up for a situation when a visit might be completed at the end of the day with a beneficiary and the documentation is completed the next day. The concern I have is that another coordinator pointed out that they had received a "not met" at a recertification because the dates on the note did not match.
2. Issue: Date on PV Progress Note

   No, it is not acceptable to have two different dates of service on the Professional Visit Progress Note. The date on the front of the note and the signature date must be the same – this is the date that services were provided.

3. When typing progress notes in the narrative section, there is only enough room for one or two sentences. The page moves and pushes signature off of page.

   The narrative section is designed for mom's response to the intervention provided. As such, the space available in that field is limited. If you want to write additional documentation, include it under "other visit information".

4. Provide detail describing completing the top of professional visit progress note. Not just saying "fill it out." Describe exactly what is required for "Reviewed this visit."

5. Topics reviewed: Please put this line in writing for new and old staff training: What are the instructions?
6. On progress note: Reviewed this visit. If "neither" is checked, is TOPIC REVIEWED always blank? Can you write in something you talked about that is on the POC 1?

   This section has been revised in the new Professional Visit Progress Note, which you will be required to use as of January 1, 2015. The form itself now prompts you to provide the required information. The form is currently posted at web site under "Forms Effective October 1, 2014."

7. Just to clarify, we do not have to put anything in other visit info/referral follow-up? We have been explicitly told before that we must have something there.

   You do not have to put anything in these two fields if you have nothing to document there. But remember, you must follow-up on all referrals within 3 visits from the date that the referral was made.

Discharge Summaries

1. When will nutrition be added to the Maternal Discharge Summary?

   This has been done.

2. Can a "NA" option be added to the question on D/C summaries for MHP contacted? Some tribal sites don't work with MHPs. So it makes it look like we aren't w/ no "NA" option.

   Tribal communities are exempt from MHP enrollment in MHP and DCH is well aware what you mean when you check the "no" box.

3. At the HV conference, I believe we voted to have last date of service mean last attempted contact and we were told that was ok moving forward. Why did this change back again?

   No, it was decided that the last date of service was the last in-person contact/visit or billable service.

4. Need clarification on date services end and D/C date.

   The date services end is the date of the last billable contact (face-to-face visit, transportation, CBE or parenting class). The discharge date is the date that the completed Discharge Summary is entered into the DCH MIHP database through SSO.

5. What is the day of discharge? Is it last attempt or last actual face-to-face visit? And is it 4 months of inactivity from last attempt or last face to face?

   The date of discharge is the date that the Discharge Summary is entered into the MDCH MIHP database. For a pregnant woman, this must be within 30 days of the date her MIHP eligibility ends. For an infant, this must be within 30 days of the date infant services are concluded or after four months of inactivity, counting from the last billable contact (not four months from the last attempt to contact).

6. If you want date of last billable visit to be the closure date, can there also be a place for last date of contact to reflect that client has not been closed past the 30-day closure guidelines?

   The Contact Log, which is required as of Nov 1, 2014, will capture activity after the last billable contact.

Beneficiary Declines Service after RI

1. For beneficiaries who complete the RI but decline service, pulling POC's 1-3 and then discharging them takes a lot of time. Could there be a way that when entering the RI into the database, we could indicate that the beneficiary declined services?
2. When an MRI is completed and client declines the program, is MDS required? If so, can the MDS have a checkbox to auto-populate the field?

   At this point, the answer is no. However, we are looking into making this process less cumbersome.

CPS

1. Please email us when the online mandated reporting training goes live.

   We will do this.

2. Could you please put in writing Colin Parks' answer regarding not needing a signed consent prior to speaking with CPS on an open case?
3. I thought the DHS-CPS segment would address consent to release info to CPS re:
   a. If CPS calls us to ask if a client is receiving MIHP services, how much info can we give, if any?
   b. To give any information, should CPS be forwarding us a consent signed by the client?
   c. Conversely, If we made a referral to CPS and they call for more info should we give:
      - Verbal only?
      - MIHP records? Or does this require a subpoena?
      - Other written summary of MIHP services?

   You are not required to get a signed consent to talk with CPS during an open investigation, but take care to only share information that is valid to the current investigation (e.g., don't talk about past history). During an open investigation, CPS will not subpoena you for information. CPS has 30 days to complete the investigation and make a disposition of the case. If the disposition involves the opening of a CPS case and CPS contacts you at that point, ask the CPS worker for a copy of the MDHS Authorization to Release Confidential Information (DHS-1555-CS) signed by the beneficiary before providing information.

Medicaid

1. We can't bill for helping someone apply for Medicaid – what if their Medicaid is cut off during pregnancy, we can't bill for it at all?

   If it appears that a woman loses Medicaid eligibility during her pregnancy, please contact the appropriate DHS case specialist.

2. Please clarify doing maternal postpartum visit and IRI on the same day. Per the Op Guide, this is not to be routine practice. It is to be done in certain circumstances (e.g., MOB request or distance traveled). Coordinators are stating this was not made clear.

   Performing visits on the same day is only recommended in special, limited, circumstances so as not to overwhelm the new mother with information. The Medicaid Provider Manual, MIHP Chapter, Section 2.9A, outlines the maternal postpartum visit: "An MIHP provider may complete and bill an infant risk identifier visit separate from a maternal postpartum professional visit. A maternal postpartum professional visit may be made on the same date of service as the infant risk identifier visit. Providers MUST document when both visits need to be done on the same date of service. The maternal visit MUST be a minimum of 30 minutes and be reflected in the professional note."

3. Put a cap on how many MIHP programs can be in a county. Your will get better outcomes and patients will get better care.

   Please see the response to question 4.

4. How many more new agencies will the state allow to apply?

   Provider eligibility is discussed in the Medicaid Provider Manual, General Information for Providers, Section 2, "An eligible provider who complies with all licensing laws and regulations applicable to the provider's practice or business in Michigan, who is not currently excluded from participating in Medicaid by state or federal sanction, and whose services are directly reimbursable per MDCH policy, may enroll as a Medicaid provider."

5. We need more Medicaid support. Ex: Getting answers on when they will fix Medicaid so that it will back date.

   Concerns or questions about eligibility may be directed to the individual's DHS case specialist. If questions remain, or further DHS issues arise, they may be brought to the attention of the DHS director.

6. St. Clair County HD has MIHP clients that our clerks or DHS did MAGI application for Medicaid (clerks had training and are certified). State assigns Medicaid. Some are inappropriately assigned to MI Child even if they are 27 or 34 years old. Working with local DHS (who also are seeing lots of this) to reverse this error. It's taking months. In the meantime, client can't see doctor (per them) or visits from MIHP.

   Please see the response to question 5.

7. If parents choose an office visit, can they get a gas voucher to MIHP visits? Doesn't happen often, but sometimes clients 30-60 minutes away will need an office visit, but we haven't been giving gas vouchers.

   Transportation support offered to beneficiaries enrolled in the MIHP program (described in the Medicaid Provider Manual, Chapter MIHP, Section 2.1), is for visits related to the health-related appointments. MIHP is a home visiting program. If a beneficiary elects to have their visit occur in the provider's office, the beneficiary will be reimbursed for travel.

8. MDCH mandates all pregnant women be referred to MIHP. Women average coming on Health Plans 1-3 months after enrollment process, at best. To improve: earlier referral and enrollment rates in MIHP, if MDCH mandated all OP providers refer women to MIHP on their first prenatal visit potentially would impact this.

   This is being discussed in the Medicaid Managed Care Division.

9. Are CBE classes billable for any mom or only first-time moms?

   MIHP childbirth education may be billed one time per beneficiary per pregnancy.

10. Noticed that NFP requires nurses in their program have a minimum of a baccalaureate degree. Why does MIHP only require an associate's?

    As stated in the MIHP Chapter of the Medicaid Provider Manual, Section 1.2, Staff Credentials, nurses must possess current Michigan licensure as a registered nurse and have either a Master's of Science (MSN) or a Bachelor's of Science (BSN), and at least one year of experience providing community health, pediatric and/or maternal/infant nursing services OR a nursing diploma or Associate Degree in Nursing (ADN) and at least 2 years of experience providing community health, pediatric and/or maternal/infant nursing services.

Healthy Michigan Plan (Medicaid Expansion)

1. Do people with Healthy Michigan Plan have to pick a managed care health plan?

   Yes.

2. If on Medicaid for pregnancy and delivery, client has 2 months postpartum Medicaid coverage. If woman has to then reapply for Healthy Michigan Plan at end of Medicaid coverage, will there be a gap in coverage?

   DHS attempts to ensure there is no gap in coverage for women who will be eligible for State funded programs. It should not be assumed that the woman will still meet eligibility requirements for any program.

3. Where can we get copies of Healthy Michigan Plan brochures?

   Information about the Health Michigan Plan can be accessed on the MDCH web site at http://www.michigan.gov/mdch/0,4612,7-132-2943_66797---,00.html

Nurse Family Partnership (NFP)

11. NFP billing MIHP transportation - for a health system, unless that client is a "patient," we are unable to "bill" for transportation without going through an admissions process which cost a fortune – we won't be paid.

    Thanks for letting us know. It will help us in our planning.

Free Items

1. Free items – State consultant says fine, as long as items are donated. That's conflicting – don't make sense. How is it monitored (donation vs purchase)? What is the limit for donations? (Still unfair advantage and illegal.)
2. How is it that we cannot tell them that we will assist them with free items but you want us to provide them with items such as baby items, diapers, clothing, etc.? Please provide us with more resources within Wayne County for such items, including furniture.

   A MIHP agency cannot entice a beneficiary to enroll in their MIHP by offering free items, but it is expected that an agency will assist the beneficiary in obtaining needed items during their time of services.

   It is the role of the MIHP care coordinator to monitor and coordinate all MIHP care, referrals, and follow-up services for the beneficiary (Medicaid Provider Manual, MIHP Chapter, Section 2.6, Care Coordination). As stated in the MIHP Operations Guide, Chapter 4, Section 4.1, "The care coordinator advocates for the beneficiary as necessary … the provider ultimately aims to empower the beneficiary to successfully navigate the health care system herself." Information regarding accessing community resources can be located in the MIHP Operations Guide, Chapter 7, Section 7.5.

Certification Reviews

1. What forms have changed for Cycle 5?

   All the current forms are on the web site.

2. If your survey was done in Cycle 4, why is that your 6th month review is in Cycle 5? (If an agency hasn't passed one cycle, why move them to the next one?)

   Every agency is evaluated on the same criteria over an 18-month cycle. It wouldn't be prudent to apply criteria that are no longer in effect or that have changed. That said, there are no significant differences in the review criteria from Cycle 4 to Cycle 5.

3. To save on paper, can reviewers have a laptop to be able to see RIs and D/C summaries? Once progress notes go online (especially), wouldn't it make sense to give them access to SSO than spending time and printing excess forms?

   We will take this under consideration.

MIHP Enrollment Percentages by County

1. Where is Bay County on the MIHP enrollment percentage?

   Please get that data from your consultant.

2. I am a bit concerned about the % of highest MIHP enrollment numbers as I think they are a bit low for our counties (Antrim, Charlevoix, Emmet & Otsego). I think we're higher than that.

We will look at this as we generate more reports.

3. The chart is misleading because it doesn't show the number of women we have attempted to enroll who didn't want to participate.

   You're correct. We don't capture data on the number of women who decline. We haven't been able to come up with a feasible way to collect it. Do you have any ideas?

Confidentiality

1. Do you have to have a specific consent for the Health Plan to view a client's entire record?

   No, Health Plans have the right to see the beneficiary's entire record. This is because of the HIPAA exemption for payment, treatment and operations.

2. If using a personal cell phone, it should be encrypted due to HIPAA – what if patient leaves a message and you lose your phone, etc.? Same as a lap top!

   We think you have identified an important issue and we will take it to the MDCH Office of Legal Affairs.

3. Operations Guide 8.24 #7 says if beneficiary doesn't consent to release PHI to medical provider, we don't send her info. This has come up before and we were told because client is a "Medicaid client" we don't need their consent for purposes of billing, care. We had to D/C high risk client because of this. So being a Medicaid client, do we have the right to talk with OB about treatment/risks without consent?

   In respect to questions 1 and 3:

   All records are of a confidential nature and should not be released, other than to a beneficiary or his representative, unless the provider has a signed release from the beneficiary or the disclosure is for a permitted purposed under all applicable confidentiality laws unless the client poses harm to himself or others. For claims purposes providers are required to permit MDCH personnel, or authorized agents such as Managed Health Plans, access to all information concerning any services that may be covered by Medicaid. This access does not require an authorization from the beneficiary because the purpose for the disclosure is permitted under the HIPPA Privacy Rule (Medicaid Policy Manual, Chapter General Information for Providers, Section 15.5, Confidentiality).

Documentation

1. Can we use our own established contact log or does it have to be the state's MIHP contact log?

   A contact log is required but you don't need to use the state version. You can use your own.

2. Can we use a signature stamper on paperwork, letters to doctors or does it have to be a signature?

   You can use a signature stamper for letters, but not for other documentation.

3. Should apostrophes and hyphens be included with names entered into SSO? We have had duplicate entries into SSO due to names with/without apostrophes & hyphens.

   We have to look for multiple combinations with hyphenated and apostrophized names because there are discrepancies. We are sorry that this is more work for you. Please enter the name as it is officially spelled.

4. How and where would you like us to document communications between disciplines regarding a client?

   Please document these communications on the contact log or progress note.

5. When a client refuses to transfer but has already signed a transfer, what documentation does the original agency need to maintain to continue to see the client?

   The original agency must secure a statement in writing from the beneficiary indicating that she has rescinded her transfer request.

Statewide Database

1. A statewide database to access who is on MIHP and what agency the beneficiary is enrolled in – is an excellent way to improve access and outreach of MIHP. Could be a mini-MCIR.
2. As MHPs are able to access the MIHP EHR/database, it would be very helpful if hospitals and prenatal providers could access this information. During our visits to birthing hospitals, there was much discussion about care transitions from the community to the prenatal care provider/hospital and back to the community to facilitate continuity of care and positive health outcomes.

   MHPs will have access to the MIHP/EHR database. At some point, other entities may gain access, but for now, the MHP or MIHP is responsible for communicating with medical providers and hospitals.

Training and TA

1. Could you please offer more classes on progress notes and documentation?
2. Please have more trainings that include progress note completion and review. This was really helpful.
3. Coordinator meetings should be utilized to go over forms and the areas of certification that are most frequently missed.
4. It would be great to have someone here from DHS.
5. Speakers for meetings: DHS workers/staff/supervisors. Many of our problems can't be answered b/c their agency seems to be in the middle of many of our issues.
6. Clearly we need a DHS representative at our next meeting. Someone with thick skin!
7. At every coordinator training I have pleaded for more time for questions to the MIHP Leadership Team and time for networking with other coordinators. It always feels so rushed. Today there was no time left to address questions about what Rose Mary presented.
8. These days are consistently too long with too much information. Most participants here drove 2-4 hours to get here (each way). Please consider the length of the day when planning future meetings. Long days are not respectful of participants or presenters.
9. Why does the meeting always end on a depressing note?

10. Training suggestion: Trauma-Informed Care.

    We're taking all of the above comments (1-10) into consideration as we plan the March 2015 meetings.

11. The temperature is uncomfortably COLD!!!
12. Room is cold.

    Sorry, but large meeting rooms are notoriously hard to regulate to satisfy all participants. In the same room, we see some people putting on coats while other people are fanning themselves. In any season, bring extra LAYERS. Cold people can add layers, but hot people can't take their clothes off.

13. Does MIHP plan to have a formal IT help line?

    We wish we could.

14. Still not receiving quarterly reports. Last and only report on SSO was for another agency.

    You may access your reports through SSO file transfer. If you have difficulty with this, contact your consultant.

15. For webinars, please have transcript available. It is very helpful to have in writing to reference vs trying to find where something is mentioned in a 30-45 minute webinar.

    We will discuss this more internally.

Other

1. Could an Arabic-speaking consultant please locate some Arabic brochures on safe sleep, SIDS, car seats and shaken baby?

   Arabic agencies are happy to share resources. Contact the agencies and if you have any difficulty obtaining what you need, contact your consultant.

2. Concern: Agencies knowing a client is being serviced by another agency yet they state their agency specializes in housing only.

   This issue has been raised with the agency that assists with housing. Please let consultant know if concerns continue.

3. How do we adjust for babies less than 40 weeks? I can't find anything online and the ASQ calculator will only adjust for less than 37 weeks, so it doesn't work. We don't have capabilities to use electronic RIs in the home.

   The March of Dimes has donated cardboard gestation calculators to MIHP, which will be mailed to all agencies in the near future. You can use these to calculate the appropriate Bright Futures age when you are in the field. Until then, please see

www.pediatrics.emory.edu/divisions/neonatololy/dpc/faq.html in order to determine gestational age.

4. Operations Guide 8.18 paragraph 3 says POC is client focused and client selects priorities to address – this sounds great, but not so client focused when we have to address any high risks in first three visits.

   Clients always have the option to refuse to address risks, including high risks.

5. Is the projected date for ability to upload Risk Identifier info into our computer data system? We have a signed and submitted data use agreement.

   We are not at this stage of the IT development yet.

6. MIHPs in Saginaw need constructive ways to collaborate and work with WIC in our county. We are hitting roadblocks and it has been a challenge to get referrals and connect with WIC recipients. How can we get Saginaw County WIC to make referrals to our agencies or let us connect with their clients at WIC offices?

   Changes are underway in Saginaw County. Stay tuned.

7. What are barriers for MIHP providers to use more infant visits (additional 9 + 18 if drug exposed)?

   We will see if we can get feedback from our agencies on this.

8. It would be helpful to have "tools" for promoting parent-child dyad that the MIHP professional could use during home visits – some of these things are part of the PAT curriculum or other curricula.

   We agree and are working on this.

9. Looking at the programs that are evidence-based for the reduction of child injuries, child abuse & neglect and decreasing ER visits, I think it would be helpful if MDCH MIHP staff could review literature and see what components of these programs could be incorporated into MIHP to help strengthen MIHP in this domain. For example, is it intensity of visits, curriculum, specific education components?

   Deborah Daro, Chapin Hall at the University of Chicago, is one of the key researchers on home visitation in the US. The info below is taken from her presentation titled, Home Visitation: The Cornerstone for Effective Early Intervention.
   PDF]Panel 2 - Daro (3 of 3) PowerPoint, Home Visitation

   Promising service characteristics

   - *Solid internal consistency linking program elements (curriculum) to desired outcomes*
   - *Begin at birth or sooner (for CAN outcome)*
   - *Engage families in services and sustain involvement long enough to achieve outcomes*
   - *Provide direct assessment and services to children as well as parents*
   - *Solid organizational capacity*

- *Build strong linkages among local providers*

Promising staffing patterns

- *Prevention is about building relationships not delivering a product – hire relationship builders*
- *For the most intensive services, maintain low caseloads (15 per worker)*
- *Provide staff comprehensive initial and inservice training opportunities*
- *Provide staff multiple opportunities for individual and group supervision*

What elements remain unclear?

- *The appropriate target population*
- *The importance of curriculum consistency*
- *The optimal service duration and intensity*
- *The critical qualifications for home visitors*
- *The appropriate locus of administrative control*

Another summary of key elements of effective programs was prepared by the Minnesota Department of Health:

Home Visiting Program Design Elements of Effective Programs
Home Visiting Program Design Elements of Effective ...

10. WE WANT AN ADVISORY COMMITTEE!

This is in the works.

11. HUBS – If MIHP participates in HUB, do we have to submit all referrals to HUB?

No, but letting the HUB know which clients you are serving would be appropriate.